TINNITUS AND HYPERACUSIS CLINIC

Tinnitus History Questionnaire

Name:_____Date:_____

Nature of Your Tinnitus

What does your tinnitus sound like?

The usual site of your tinnitus (check the appropriate box):
☐ Left worse than Right ☐ Right worse than Left ☐ Left and Right about same ☐ I don't know

Is your tinnitus: ☐ Constant / ☐ Intermittent

Does your tinnitus fluctuate in intensity or loudness? ☐ Yes / ☐ No

What makes your tinnitus worse? better?

Tinnitus History

When did you first become aware of your tinnitus?
When did your tinnitus first become disturbing?
Under what circumstances did your tinnitus start?
What do you consider to have started your tinnitus?

Have you consulted any professionals about your tinnitus? ☐ Yes / ☐ No If yes, whom:

What have previous professional said your tinnitus is due to?

What treatments have you tried for your tinnitus (check all that apply):
☐ None ☐ TRT ☐ Hearing Aid ☐ Counseling ☐ Masker ☐ Music Therapy ☐ Other: _____

How successful did find these treatments?

Have you ever (check all that apply): ☐ Been exposed to gunfire / explosion ☐ Had noisy hobbies / home activities

☐ Attended loud events (e.g. music concerts or clubs) ☐ Had any noisy job ☐ Had any head injuries / concussion

☐ Had any operations involving your ear or head ☐ Used solvents, thinners, or alcohol based cleaners

Taken any of the following medications:
☐ *Quininne* ☐ *Quindidine* ☐ *Streptomycin* ☐ *Kantamycin* ☐ *Dihydrostreptomycin* ☐ *Neomycin*

Do you (check all that apply): ☐ Have loose dentures ☐ Jaw pain ☐ Grinding / Clicking sensation in the jaw

Do you regularly take aspirin or dispirin? ☐ Yes / ☐ No

Do you have any feelings of ear pressure or blockage? ☐ Yes / ☐ No

Do you find that exposure to loud sounds makes your tinnitus worse? ☐ Yes / ☐ No

General Hearing Health

Do you have any difficulties (check all that apply): ☐ Hearing when there is background noise ☐ Hearing the TV

☐ Understanding in one-to-one conversations ☐ Hearing on the phone ☐ With dizziness or balance problems

Do you find external sounds unpleasant or uncomfortable? ☐ Yes / ☐ No

Do you dislike certain external sounds? ☐ Yes / ☐ No If yes, explain: _____

Do you wear ear protection/ ear plugs? ☐ Yes / ☐ No If yes, what kind: _____

Please rank the auditory problems you experience on a scale of 1-3: 1 = most troublesome, 3 = least troublesome

_ Hearing _ Tinnitus _ Sensitivity to loud sounds

Impact of your Tinnitus

Does your tinnitus prevent you from: Falling asleep ☐ Yes / ☐ No Staying asleep ☐ Yes / ☐ No

How has tinnitus impacted your:

Work life?	Home life?	Social life?

General Health

How you would you describe your general health? ☐ Good ☐ Fair ☐ Poor
Explain:

Are you taking any medications? If yes, please specify:

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?